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ABSTRACT

Maladaptive eating behaviors are a growing phenomenon which has captured the interest of not only health and psychology professionals, but also the general public. This paper examines the various types of treatment and counseling approaches for treating anorexia nervosa and bulimia nervosa. Definitions for both disorders are provided, followed by discussion of the epidemiology of eating disorders. Similarities and differences between anorexia and bulimia are presented by comparing their psychological, behavioral, and physical characteristics. In addition to discussing several theoretical perspectives which explain the etiological factors of eating disorders, the types of treatment for these conditions are described, including medical assessments, inpatient care, outpatient care, and pharmacological treatment. In-depth discussion of various counseling approaches for treating anorexia and bulimia are offered, covering such concerns as preventative programs, factors concerning treatment selection, and characteristics of the therapist. Such factors as age, gender, severity of the illness, and motivation to change are all important when selecting treatment. Early intervention and appropriate selection of treatment and therapists are necessary in preventing these disorders from resulting in tragic consequences. Contains 20 references. (RJM)

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Treatment and Counseling Approaches for Eating Disorders

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Abstract

This paper examines the various types of treatment and counseling approaches for treating anorexia nervosa and bulimia nervosa. A definition for both disorders is provided. In addition, epidemiology of eating disorders is briefly discussed. The similarities and differences between anorexia and bulimia are presented through psychological, behavioral, and physical characteristics. Several theoretical perspectives explaining the etiological factors of eating disorders are presented. Types of treatment are discussed, which include medical assessments, inpatient care, outpatient care, and pharmacological treatment. Finally, there is an in-depth discussion of various counseling approaches for treating anorexia and bulimia. In conclusion, preventative programs, factors concerning treatment selection, and characteristics of therapists are discussed.

Treatment and Counseling Approaches for Eating Disorders

Maladaptive eating behaviors are a growing phenomena which have captured the interest of not only health and psychology professionals, but also the general public. Although the type of food eaten and the manner in which it is eaten varies from culture to culture, there appears to be an automatic process which constitutes normal food intake. Restriction and/or purging of food for the purpose of losing weight is considered atypical and has been a central concern for many. Early intervention and treatment for both the physical, and psychological variables underlying these behaviors may prevent tragic consequences.

Definition

Diagnostic Criteria

Anorexia nervosa and bulimia nervosa have both been listed as mental disorders in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition revised (DSM-III-R) by the American Psychiatric Association (1987). Each has been defined in some detail, but can easily be summarized. The features of

anorexia nervosa include the intense fear of becoming fat, weight loss of at least 25% of original body weight, and for women, amenorrhea, which is the absence of menstruation for 3 consecutive cycles. For bulimia nervosa, DSM-III-R criteria include recurrent episodes of binge eating, a feeling of lack of control over eating, a regular engagement of self-induced vomiting, and persistent overconcern with body shape and weight. Although each disorder differs to a degree, both have a feature common to each other--preoccupation with food and body weight. Horne, Van Vactor, and Emerson (1991) took the DSM-III-R criteria one step further and stated that it is not only preoccupation and overconcern, but it is also a distorted image of the body among both disorders.

Epidemiology

According to the practice guideline for eating disorders presented by the American Psychiatric Association (1993), eating disorders have increased sharply in the past decade. Victims of eating disorders are 10 times more likely to be adolescent and young adult women, coming from predominantly white,

middle to upper class families. However, APA states that there are increasing numbers apparent in older women, men, and minority groups. In support of this increase, Thornton (1990) has noted that men participating in certain sports, particularly wrestling, have reported an increasing number of eating disorder cases. These rising incidences in men may be due to the defined weight regulations that many athletes face before competition and thus, becoming very preoccupied with their weight.

Characteristics

Psychological

There are many behavioral and psychological characteristics that accompany anorexia and bulimia. Some of the psychological features that are common to both eating disorders include anxiety, low self-esteem, and depression. However, depression appears to be more common in bulimics, often to the point of experiencing suicidal ideations (Kerr, Skok, and McLaughlin, 1991). This may be due to bulimic's low frustration tolerance and labile moods. In addition, Kerr and his colleagues noted that anorexics tend to have more overcontrolling

egos, where bulimics tend to think of themselves as out of control. One possible reason for this could be due to the anorexics' proud feelings of being able to restrict themselves from eating and to sustain their appetites.

Behavioral

There are also some behavioral characteristics that show both similarities and differences in anorexia and bulimia. Some similarities include compulsive exercising, overuse of laxatives and diuretics, and bizarre activities that include food, such as wanting to bake sweet foods frequently. Emerson and Stein (1993) reported that 79% of eating disorder victims enjoyed cooking for others.

There many differences between the two disorders, yet the most common reported is impulsive behavior. Bulimics tend to show very poor impulse control in comparison with anorexics (Emerson and Stein, 1993; Kempley and Weber, 1993). A study by Emerson and Stein (1993) found that bulimics were more likely to use drugs, steal, and cheat in school. In addition, Kerr et al., (1991) noted that anorexics have more sexual

inhibitions, whereas bulimics are more likely to engage in impulsive sexual interactions. This issue of impulsivity among bulimics appears to be directly related to their loss of control with eating binges.

Physical

When considering treatment for eating disorders, it is important to take into account the physical complications that result from restricting and purging food intake. Some of these health problems include low potassium levels, low blood pressure, high metabolic rate, bradycardia (abnormal heart beat), and gastrointestinal disturbances (Agras, 1987). In addition, as noted earlier, anorexics experience a cessation of menstrual cycles. From what appears to be an emotional, mental disorder, these physical complications are horrifying consequences that could result in death.

Theoretical Perspectives

Before discussing types of treatment and approaches to counseling, examining several different theoretical perspectives to the etiology of anorexia and bulimia provides a better understanding for eating

disorders. There has been much research attempting to offer explanations for why eating disorders exist. Jones and Nagel (1992) reviewed and differentiated the various perspectives into the following three theories: Sociological/Environmental Theory; Family Systems Theory; and Psychogenetic Theory.

Sociological/Environmental Theory

The first theory proposes that eating disorders result from societal pressures. Society honors thinness and stigmatizes those who are overweight. A common example are women's magazines that not only portray young women in risque attire, but also offer several dieting strategies to become thin. These magazines are often too idealistic and not realistic to the average, actual shape of most women's bodies. In other words, the models in magazines are not representative of most women.

Family Systems Theory

The second perspective suggests that eating disorders are associated with a style of family interaction where adolescents are prevented from developing as individuals. These families are often

psychosomatic with characteristics that include enmeshment, overprotectiveness, rigidity, and lack of conflict resolution (Jones and Nagel, 1992). From this prospective, it is easy to understand why anorexics want something of their own to control, like eating behaviors. Bulimics have tendencies to act out in anti-social ways, such as stealing.

Psychogenetic Theory

The final theory has not received as much attention as the previous views, but does appear to have credible justification for the existence of eating disorders. These theorists propose that there is a predisposition for eating disorders at birth. Even though there are no exact conclusions as to what these genetic predispositions may be, Jones and Nagel (1992) report that there may be defective neurobiological processes that would normally control feeding behavior. However, they report that these defective processes are probably only manifested through the environment or the family.

Treatment

Medical Assessment

The first necessary approach to treating eating disorder victims is to do a complete medical assessment. The physical complications mentioned earlier will need immediate attention before the psychological issues underlying the victims can be addressed. A medical assessment is also important, especially for anorexics, to confirm that the drastic weight loss is not due to any other medical problem. Medical treatment becomes a first priority when anorexics are so emaciated that they are near death. Stunkard and Mahoney (1976) discussed a report of a woman whose weight had fallen from 118 pounds to 47 pounds over a seven year period. It is obvious that any full grown woman whose weight had decreased to 47 pounds would need immediate medical attention.

Inpatient Treatment

Inpatient treatment is often for those eating disorder victims whose condition is chronic. Kempley and Weber (1993) suggested that this type of treatment is not generally geared toward bulimics, unless they are experiencing severe medical complications, such electrolyte imbalances, or making suicidal threats, in

which case psychiatric care may be appropriate. Inpatient psychiatric treatment centers around a highly structured environment with multi-faceted programs, including individual, group, and family therapy. Although weight gain is the first priority of treatment for anorexics, it should not be the exclusive attention during inpatient psychiatric care (Beumont, Russell, and Touyz, 1993).

Outpatient Treatment

After medical conditions have improved and weight has been maintained, anorexics are often referred to outpatient care. Bulimics may go directly to outpatient care after the medical assessment confirms that their condition is not too severe. Many researchers suggest that outpatient care is only successful for those who project a motivation to change (Beumont et al., 1993; APA, 1993). Outpatient treatment may include individual therapy, family therapy, group therapy, or any combination of the three.

Outpatient treatment often follows the same principles as inpatient treatment, except that

outpatient care may be less structured, as the nutritional rehabilitation and psychotherapy overlap more (Kempley and Weber, 1993). In addition, therapists now put much effort into helping individuals structure free time so they can become less preoccupied with food.

Pharmacological Treatment

Although several medications have been utilized in the treatment of anorexia and bulimia, most have not had impressive results. Most medications used have included tricyclic antidepressants for victims with depression that persists despite any weight loss. However, there is a great concern that malnourished victims are more prone to side effects than to the responsiveness of the antidepressants. This involves an increased risk in hypotension and arrhythmia, particularly for purging bulimics who are experiencing dehydration (Beumont et al., 1993). In addition, the use of antidepressants may result in even further negative outcomes, such as poor compliance or risk of abuse. Overall, medications for the treatment of anorexics and bulimics should be considered with great

caution. They should never be used alone as treatment, but rather in conjunction with psychotherapy. Although medications may suppress symptoms like depression, they do not modify any behaviors or thoughts regarding food and weight.

Counseling Approaches

Behavioral Therapy

Behavioral therapy has often been used in the initial treatment of restoring body weight for anorexics. Two types of approaches, systematic desensitization and reinforcement, have been utilized in treatment. Stunkard and Mahoney (1976) described desensitization as the focus on food itself, attempting to decrease or "desensitize" the irrational fear of food. This approach has not gained as much attention as the reinforcement approach to treatment. This angle emphasizes the restoration of body weight as opposed to eating behavior. Reinforcement consists of praise and rewards for eating more, as measured by caloric intake and weight gain (Agras, 1987). Pleasurable activities, such as walks outside or watching television, become contingent upon small increments of weight gain.

However, often in hospital settings, patients may realize that through positive reinforcement they do gain weight, so they continue to eat so they can be discharged. The hospital has become an aversive and restrictive environment, so patients behave a particular way in order to be released. In cases like this, it may be beneficial to write up behavioral contracts that states the patients will remain in the hospital for a specified amount of time, regardless of the amount of weight gained.

Behavioral therapy has also been used in treating bulimia. However, it does not necessarily focus on weight restoration, as it does for anorexia. Rather, behavioral therapy may utilize self-monitoring to increase awareness of eating patterns and teach alternative coping skills (Kempley and Weber, 1993). Reinforcements may be used to modify the amount and rate in which bulimics eat. For example, therapists who are counseling highly motivated bulimics can teach the clients to reward themselves when they provide a longer period of time, such as 20 minutes, to eat a substantial and healthy one-portion meal. A reward for

doing this may be spending Saturday afternoon at the mall. This helps bulimics learn that there are alternatives to their eating patterns and that they can acquire self-control when around food.

Overall, behavioral therapy has shown favorable outcomes when treating anorexia and bulimia. However, Pomerleau and Brady (1979) have recognized that the use of behavioral treatment alone has long been criticized. They state the use of behavioral principles exclusively have had limited application after discharge from inpatient settings. As behavioral modification does not deal with psychodynamic variables, it should not be the main focus of treatment in follow-up, outpatient therapy.

Cognitive Therapy

Due to the disturbed ideological functioning of anorexics and bulimics, cognitive therapy has received much attention. There are irrational thought processes, especially among anorexics, where victims claim to "feel fat" even when emaciated. Furthermore, bulimics have cognitive distortions that reflect their eating behaviors, attitudes, and self-image. These

disturbances in thoughts and perceptions have affected the emotional, social, and physical lifestyle of anorexics and bulimics. Cognitive therapy attempts to induce mature insights to maladaptive ideologies to promote more effective coping (APA, 1993).

Therapists may use highly directive approaches to change the irrational thoughts of food and self among anorexics. As many truly "believe" that they will become obese if they do not abstain from eating, therapists may challenge them and directly provide them with alternative ways of viewing the self. In other words, therapists must also help anorexics develop accurate body images by challenging their distortions. However, because control over behaviors and thoughts is of such vital importance, research has shown that this approach has often been considered coercive and intrusive by those with anorexia (APA, 1993). They are often very adamant about maintaining control, and "believe" that nothing is wrong with their restricting eating behaviors. It appears that this approach must be addressed in a delicate and gradual manner. Cognitive therapy appears to be a more popular method

for treating bulimia. While their ideologies must also be challenged in the same way as anorexics, their abnormal attitudes about body shape and weight become the target for therapy. It may often be assumed by bulimics that shape is a valid frame of reference for judging self-worth (Kempley and Weber, 1993). Therefore, therapists help them substitute shape with a more realistic interpretation of judging self-worth. As a result, they learn to recognize connections between their dysfunctional thoughts and behaviors.

Cognitive-behavioral Therapy

Wilson and Fairburn (1993) discussed a mix of both cognitive and behavioral therapy for treating anorexia and bulimia. As mentioned previously, the cognitive aspect is utilized to decrease distortions of body image (Kempley and Weber, 1993), and the behavioral aspect is utilized to modify dysfunctional dietary restraints (Wilson and Fairburn, 1993). Thus, Cognitive-behavioral Therapy (CBT) is designed to interrupt the pattern of restrictive dieting and binge eating while challenging the distorted beliefs that accompany these disorders. Here, counseling techniques

include skills training, education, and anxiety reduction through restructuring irrational cognitions. (Pomerleau and Brady, 1979).

Wilson and Fairburn (1993) divided this type of individual therapy into three components. First, education about anorexia is explained and an orientation to the goals of treatment is provided. Within this component the eating disorder victims are offered encouragement and advice for self-regulatory strategies to resist self-starvation and purging. The ultimate goal during this phase is to return the victims to three healthy meals per day.

The second phase has an increasingly cognitive focus. Here, anorexics and bulimics are taught to identify their dysfunctional thoughts and attitudes regarding weight and eating. Under the guidance of therapists, they are also taught methods to resist vomiting and cope with overcontrolled dieting or spontaneous impulses.

The final phase simply focuses on the use of relapse prevention strategies. This portion of CBT is usually done on an outpatient basis, where there is a

continuation of self-regulatory eating behaviors and a focus on coping with high-risk situations.

A study by Telch, Agras, Rossiter, Wilfley, and Kenardy (1990) was designed to test the short-term effects of CBT for bulimics. By treating binge eating patterns directly, the results showed that, at the 20-week assessment, binge eating episodes significantly reduced with CBT. However, at the 10-week assessment, a significant amount of relapses occurred. This suggests that extending treatment with additional training is essential to enhance the maintenance of controlling binges.

Family Therapy

An approach to counseling that is often combined with individual therapy is family therapy. Very often anorexics and bulimics are affected by the family and the family is affected by the eating disorder behaviors. Although not all families of eating disorder victims are dysfunctional, there is indeed a crisis, and the family could benefit from intervention (Kempley and Weber, 1993). Family therapy appears especially helpful for individuals younger than

18 years old. This may be due to the fact that people under this age are often still living at home and need to conform to parental rules.

Family Systems Theory (Jones and Nagel, 1992) suggests that families of eating disorder victims are often enmeshed, overprotected, lacking individual autonomy, and lacking conflict resolution. Parents' failure to accept the fact that children are separate individuals can take extreme forms. Nichols (1984) stated that these parents cannot tolerate deviation or separation from their rules and thus, respond to independent ventures with extreme overcontrol.

Initially, parents are often reluctant to participate in the therapeutic process because they seem very confident with their rules and communication system. A key to beginning family therapy is for therapists not to confront the family directly with interpretations, but instead to use a positive connotation when redefining terms of the familial relationships (Gilbert, 1986). For example, redefining the relationship between a father and a daughter as one of love and concern may be more beneficial than stating

that it is rigid and overprotective. This will help family members to build trust and rapport with therapists.

Therapists also need to assess the patterns within the family that are sustaining the maladaptive eating behaviors. Kempley and Weber (1993) stated that bulimic families very often attach a special meaning to food and eating. In addition, mothers of both anorexics and bulimics never let their children feel hungry. They may boast of always anticipating their children's needs before the children have experienced discomfort. These types of abnormal behaviors can easily create the type of family environment where eating disorders develop.

After trust between families and therapists has developed and patterns have been assessed, it is important that therapists set goals for family sessions. One important goal is to help each member become more autonomous. Setting and strengthening boundaries between members can facilitate individuation. Families must be encouraged to reinforce independent actions of the members. For

example, parents can be taught to reinforce their anorexic daughters for building connections with their peer groups. This is where behavioral therapy may coincide with family therapy on an outpatient basis.

Another goal during family therapy is teaching the negotiation of rules. Learning to be less rigid and overprotective with rules will allow family members to reflect on responsibility rather than blame (Crisp, 1980). In other words, through negotiation, family members, especially younger ones, can learn to take responsibility for their actions and thus, no one else is at fault. This will greatly help anorexics and bulimics to be more assertive in the decision making processes of family rules.

A final goal that needs to be addressed is conflict resolution. Families of anorexics and bulimics often lack the communication skills needed in order to discuss an issue rationally. In addition, effective communication enhances the ability to be understanding and to give support (Nichols, 1984). Offering support reduces conflict, but not in a manner that is an overwhelming burden. During family

sessions, therapists can do role playing exercises with each eating disorder victims and other members of the family. For example, through role playing a mother can practice saying to her daughter "I support you no matter which college you decide to attend." Statements like this not only reduce any conflict between the mother and daughter, but it also allows the daughter the space needed to make important decisions on her own.

Group Therapy

Group therapy has also received but attention as being effective treatment for anorexia and bulimia. Group therapy sessions, both short- and long-term, are usually centered around formal structured activity. During the first phase of treatment, concentration focuses on normalization of eating behaviors and developing awareness of irrational thoughts and attitudes (Kempley and Weber, 1993). This is much like the cognitive-behavioral approach mentioned earlier. As group sessions progress, activities may include practicing relaxation and self-hypnotic techniques as a way to promote self-awareness and behavior

modification. In addition, social skills may be role played, in areas such as forming relationships and increasing assertiveness. As peer relationships begin to form within the group, discussion may refocus on feminist issues, such as fears concerning sexuality (Lenihan and Sanders, 1984).

Many researchers have suggested that group therapy is especially beneficial for older eating disorder victims (over 18 years old) who are no longer living with their parents. (Lenihan and Kirk, 1990; Crisp, 1980). This approach has been very common at college campuses. Lenihan and Kirk (1990) developed a program at a midwestern university using student paraprofessionals as group therapists for fellow students who were struggling with eating disorders. Beumont et al. (1993) would disagree with this approach because they claim that group therapy should only be conducted by highly skilled professionals. However, despite the criticism, Lenihan and Kirk's PACT (Paraprofessionals as Companion-Therapists) program has offered both efficient and effective interventions. In preparation for this program, each of the student

interns went through thorough screening before being selected as paraprofessional therapists. After the selection process, those chosen underwent 25 hours of intensive training, which included crisis intervention and ethics.

Although the program evaluations reported highly significant decreases in binging, purging and skipping meals, there are some limitations in this program that need to be addressed. First of all, the eating disorder students involved in PACT only went through therapy for one full semester. Secondly, Lenihan and Kirk failed to mention if these students were referred for additional treatment after the semester was over. Fifteen weeks does not appear to be adequate to treat highly complex disorders such as anorexia and bulimia.

Conclusion

Much research has been generated in an attempt to determine appropriate treatment and prevention for anorexia nervosa and bulimia nervosa. Education programs are increasing in secondary schools to teach youth about the topic of eating disorders, along with the risks and complications associated with the

disorders (Nagel and Jones, 1993). In addition, many of these programs are educating teachers to become more aware of the behavioral and psychological characteristics that manifest from restrictive eating and purging. These types of preventative programs may be an initial step to fighting this epidemic that is so rampant in our society.

There are many factors to take into account when considering which type of treatment and counseling approaches are appropriate for eating disorder victims. Age, gender, severity of illness, and motivation to change are all important when selecting treatment. A substantial time commitment for therapy is also essential in order to prevent relapse. This can become a great concern if the psychodynamic variables are not addressed during time in therapy.

Therapists' characteristics may also have an enormous impact on the treatment. Lenihan and Sanders (1984) discussed advantages to using male and female co-therapists, especially in group therapy, for helping eating disorder victims. They suggest that the notion that "thin is beautiful" is often best understood by

women therapists. On the other hand, for the female victims who are struggling with interpersonal relationships concerning males, especially fathers, male therapists offer opportunity to model a nurturing and affectionate aspect of male gender. Overall, therapists must project themselves as being comforting, nonjudgmental, and flexible. In addition, they must set firm limits and challenge anorexics and bulimics in order to bring about change in irrational thoughts and maladaptive behaviors. Early intervention and appropriate selection of treatment and therapists are necessary in order to prevent these disorders from resulting in tragic consequences, such as death.

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